Iowa Medicaid Enterprise
Provider Training 1.13.20

Case Management

1/16/2020

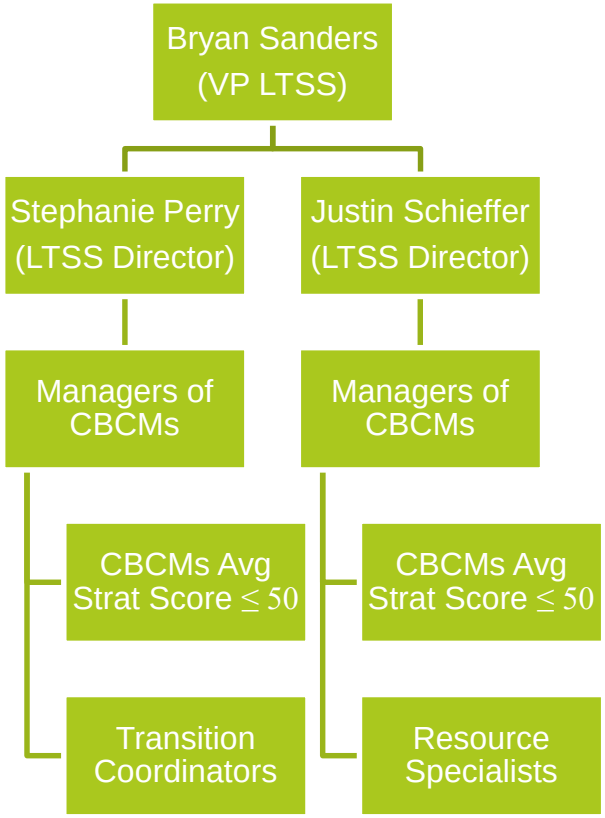
Presentation Overview

- ✓ Iowa Total Care's (ITC) Community Based Case Management (CBCM) structure
- ✓ CBCM Populations
- ✓ Case Manager Caseload
- ✓ Person Centered Service Planning Process
- ✓ Provider Interaction
- ✓ Provider Access to CBCMs
- ✓ Team Collaboration
- ✓ Denial of Services
- ✓ Application and Level of Care process
- ✓ Eligibility

Community Based Case Management (CBCM)

- The primary goal of LTSS case management services is to coordinate, monitor and link members to services and supports to allow them to live safely in their community
- Services and supports are specific to each member's unique needs
  - Outlined in the member's Person Centered Service Plan (PCSP) that is developed with the member and his/her chosen Interdisciplinary Team
  - PCSPs address all member needs including social determinants of health
  - Services and Supports include:
    - Natural Supports
    - Community Supports and Resources
    - State Plan Medicaid Services
    - Waiver Services

ITC CBCM Structure



CBCM Regional Map

iowa total care

Community Based Case Management Manager Regions

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ia health link

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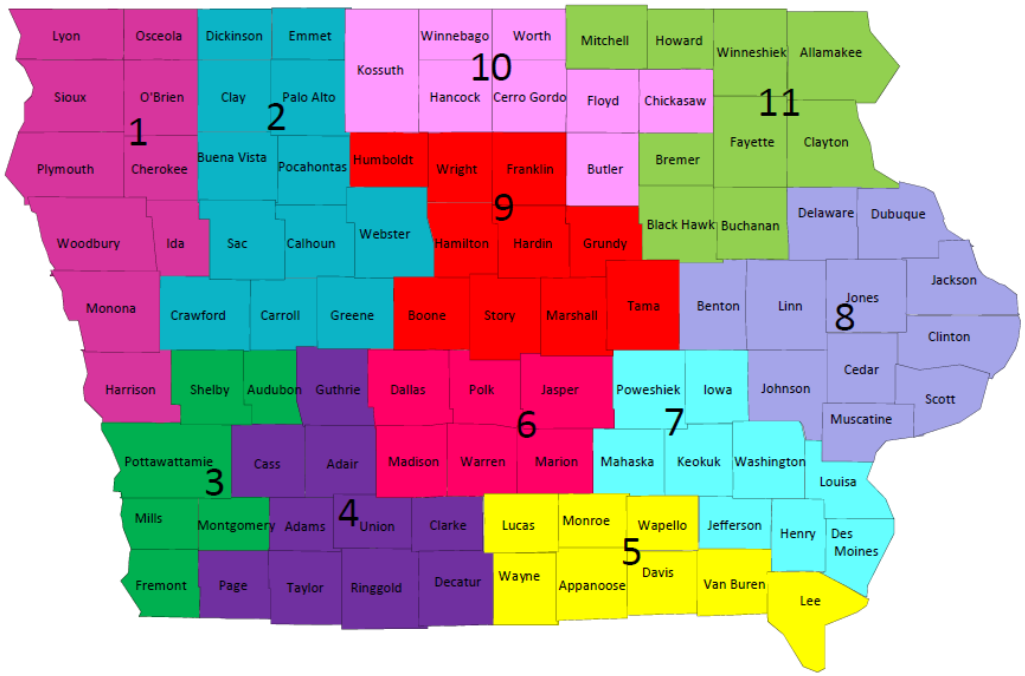


CBCM Populations

- Members who qualify for:
  - AIDS/HIV Waiver
  - Health and Disability Waiver
  - Physical Disability Waiver
  - Brain Injury Waiver
  - Elderly Waiver
  - Intellectual Disability Waiver
  - Developmental Disability (DD) Case Management

Caseload Size

- Risk Stratification
- CBCMs will have targeted caseload of ≤ 50

Category
Member has behavioral issues requiring interventions in last 6 months (hospitalization, ER visit, intensive outpatient, etc)
Member is enrolled in both a waiver and Habilitation services
Member has medical Issues requiring interventions in last 6 months (hospitalization, ER visit, nursing facility stay, etc)
Member is transitioning from nursing facility, out-of-state placement, CNRS or other high service setting.
Member has high communication needs as identified as part of the service planning process (at least 2-3 contacts per week required to coordinate services)
Member is on ID/BI waiver

Person Centered Service Planning Process

- Level of Care Assessment
- Welcome call (if a new member)
- Initial visit (if a new member)
- Pre-Person Centered Service Plan discussion
- Person Centered Service Plan meeting
- Follow up with member on new services

Provider Interaction

- Case Manager is required to contact providers on a regular basis, by phone or in person
- Provider contacts will occur quarterly or more frequently if needed
- Providers not providing direct care to the member do not need to be contacted. These type of providers are referred to as ancillary or non-direct care services and include: PERS; home delivered meals; transportation; and chore services

Provider Access to CBCMs

- Case managers will contact providers quarterly via phone to discuss how the services are going and if the care plan needs updates
- Case managers will invite providers to the yearly service plan meeting where, as part of the team, they will participate in the service planning process
- Providers can contact the case manager anytime they feel a service plan addendum is needed

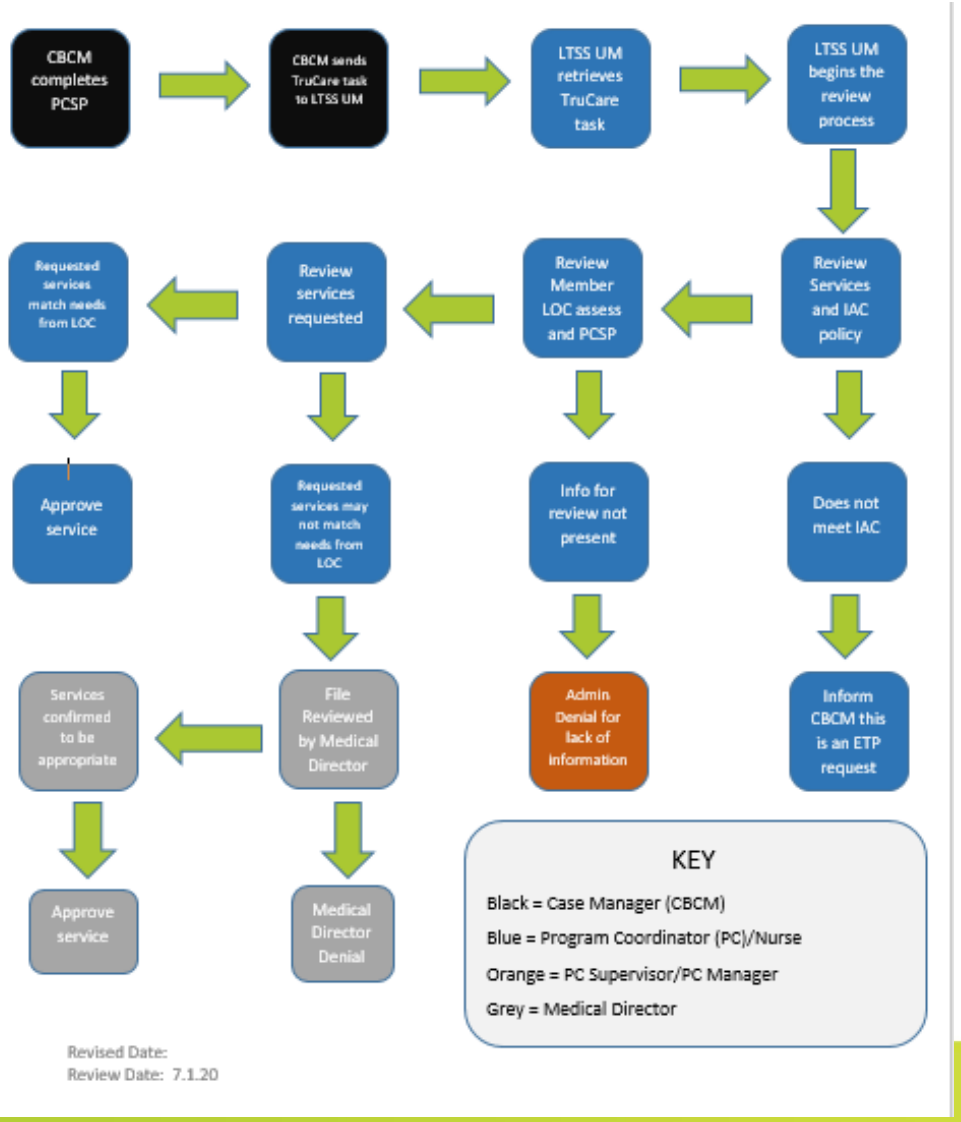
Team Collaboration

- At least once per year, a Person Centered Service Plan (PCSP) meeting will occur that will take input from both providers and members
- Case Managers will monitor and coordinate services between members and providers.
- Any part of the team can request a team meeting when needed

Denial of Services

- The Person Centered Service Plan acts as the service request
- Utilization Management reviews service requests
- When service requests do not appear to match the needs of the member, a Medical Director reviews
- If a Medical Director denies the service, the member will receive a NOA with appeal rights

Denial of Services



Application and Level of Care Process

- Applications to the waiver are processed by the Department of Human Services
- Once a member's waiver slot is open, a Level of Care (LOC) Assessment must be completed
- The Level of Care assessment, along with all other supporting documentation, are used in determining waiver eligibility
- All new determinations are completed by the Department of Human Services
- Redeterminations are completed by the MCO unless a change in Level of Care is suspected.
- When a change of Level of Care is suspected, the Department of Human Resources makes the final determination

Eligibility

- ITC helps gather required documents and LOC assessment for eligibility determination
  - Iowa Medicaid Enterprise (IME) makes the final determination
- CBCMs monitor waiver slot status
  - CBCMs will partner with providers to ensure Medicaid eligibility review paperwork is completed on time
  - Ensure 1 unit of service is used every calendar quarter
  - Help the member complete applications as needed and transition between different LOCs